IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JAMES LARRY HARRIS,	*	
	*	
	*	
Plaintiff,	*	
	*	CIVIL ACTION NO.2:07-CV-508-WHA
vs.	*	
	*	
HARTFORD LIFE & ACCIDENT INSURANCE CO., et al	*	
	*	
	*	
Defendants.	*	

DEFENDANT HARTFORD LIFE & ACCIDENT INSURANCE COMPANY'S MOTION FOR SUMMARY JUDGMENT AND SUPPORTING BRIEF

Defendant, Hartford Life & Accident Insurance Company ("Hartford"), moves this Court, pursuant to Rule 56 of the *Federal Rules of Civil Procedure,* to enter summary judgment in favor of Hartford on all of Plaintiff's claims. The pleadings on file, together with the Statement of Undisputed Facts contained in this Brief and the Exhibits filed herewith, demonstrate that there is no genuine issue as to the material facts at issue, and Hartford is entitled to summary judgment as a matter of law.

INTRODUCTION

Plaintiff alleges in his Amended Complaint that he is entitled to disability benefits under a short-term disability insurance policy issued by Hartford to his former employer, DeShazo Crane Company, LLC ("DeShazo"). Hartford denied Plaintiff's claim for short-term disability benefits because Plaintiff stated in his application for benefits that his alleged disability resulted from a work-related injury. Work-related injuries are expressly excluded by the clear and unambiguous provisions in the short-term disability policy. Hartford advised Plaintiff of his right

to appeal Hartford's determination and even identified for Plaintiff the two items of information it needed in order to approve his claim (a letter denying workers' compensation benefits and a workers' compensation reimbursement agreement). Plaintiff did not appeal Hartford's decision and never submitted any additional information to Hartford. Binding precedent in the Eleventh Circuit establishes that a plaintiff in an ERISA action must exhaust available administrative remedies prior to filing suit. Plaintiff failed to exhaust the administrative remedies available to him under the short-term disability policy prior to filing this ERISA action. Hartford, therefore, is entitled to summary judgment as a matter of law.

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STATEMENT OF UNDISPUTED FACTS

1. On or about November 1, 1999, Hartford issued the short-term disability policy, No. GRH-218370 (the "Policy"), to DeShazo. (*See* Policy, at 00006, attached hereto as "Exhibit A"). The Policy provides short-term disability coverage to insured persons, consisting of eligible participating employees of DeShazo. (*Id.*).

2. For the purpose of making benefit determinations under the Plan, Hartford was expressly vested with "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy." (*Id.* at 00014).

3. Pursuant to the Policy, an employee is entitled to receive short-term disability benefits for a maximum of twenty-five (25) weeks if he or she "become[s] Disabled from a covered accident, sickness, or pregnancy." (*Id.* at 00006).

4. The Policy provides, however, that certain "Disabilities" are not covered. The Policy provides, in pertinent part, as follows:

EXCLUSIONS

What Disabilities are not covered?

The plan does not cover, and no benefit shall be paid for, any:

1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability caused by your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
4. Disability caused or contributed to by an intentionally self-inflicted injury;
5. **sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed**; or
6. injury sustained as a result of doing any work for pay or profit for another employer.

(*Id.* at 00011) (emphasis added in ¶5).

5. In approximately 2004, Plaintiff was employed by DeShazo as a welder. (*See* Am. Compl. at ¶¶ 2,6; *see also* February 2, 2005 letter, attached hereto as "Exhibit B"). In December of 2004, Plaintiff's eyes were injured while he was working. (*See* Ex. B). On or about December 21, 2004, Plaintiff filed a claim for short-term disability benefits under the Policy. (*Id.*; *see also* Am. Compl. at ¶6). In his application for benefits, Plaintiff advised Hartford that his injury was related to his occupation and that "welding injured my eyes." (*See* Ex. B at p. 1).

6. Plaintiff's claim was assigned to Hartford Claims Examiner Andrew Walton. (*See, e.g.*, Ex. B). Mr. Walton reviewed Plaintiff's application and based on the information provided by Plaintiff, concluded that the injury to his eyes appeared to have been work-related. (*Id.*). As discussed above, the Policy expressly excludes coverage for any injury for which workers' compensation benefits may be paid. (*See* Ex A, at 00011).

7. Accordingly, by letter dated February 2, 2005, Hartford advised Plaintiff that based on the information he provided in his application for benefits, Hartford could not approve his claim. (*See* Ex. B at p.1-2). Hartford specifically cited the Policy exclusions for "sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed." (*Id.* at p. 1) (emphasis removed). Additionally, Hartford informed Plaintiff as follows:

> You [Plaintiff] have advised that your disability is related to your occupation as a welder. Specifically, you have stated that "welding injured my eyes." Based on this information and how it relates to the policy guidelines listed above, **we are unable to approve you disability benefits *at this time*.**
>
> The following information, not previously submitted, is necessary for a determination of your claim: specifically,
>
> 1) a letter of denial from Workers' Compensation, and
>
> 2) a signed/dated Workers' Compensation Reimbursement Agreement (enclosed).

(*Id*. at p. 1-2) (emphasis added).

8. In its letter, Hartford advised Plaintiff of his right to appeal Hartford's determination. (*Id.*). Hartford informed Plaintiff that once it received his appeal, it would review his entire claim, including any new information, and advise him of its decision. (*Id.* at p. 2). Hartford also advised Plaintiff of his right to bring a civil action under ERISA. (*Id.*). Notably, Hartford instructed Plaintiff that his right to sue under ERISA did not ripen until after Hartford considered his appeal and informed him of its final decision. (*Id.*). Indeed, Hartford advised Plaintiff, "[a]fter your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA." (*Id.*).

9. Plaintiff did not appeal Hartford's decision. In fact, Plaintiff never submitted any additional information to Hartford.

10. On April 24, 2007, Plaintiff filed this lawsuit.

ARGUMENT

A. Standard of Review

Rule 56(c) of the *Federal Rules of Civil Procedure* provides that summary judgment shall be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The party seeking summary judgment has the burden of demonstrating to the Court the lack of a genuine issue of material fact. *See, e.g., Riley v. Newton*, 94 F.3d 632, 638 (11th Cir. 1996). The movant discharges its burden by "'showing' – that is, pointing out to the district court – that there is an absence of evidence to support the nonmoving party's case." *Id.* Once the moving party satisfies its initial burden under Rule 56(c) of establishing the absence of any genuine issue of material fact, the burden shifts to the nonmovant to "come forward with 'specific facts showing that there is a genuine issue for trial.'" *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting *Fed. R. Civ. P.* 56 (e)). Put differently, the nonmovant must "demonstrate that there is indeed a genuine issue of material fact that precludes summary judgment." *See Clark v. Coats & Clark, Inc.*, 929 F.2d 604, 608 (11th Cir. 1991). A mere scintilla of evidence supporting the nonmoving party's position will not suffice; there must be substantial evidence in order to survive the moving party's motion. *Allen v. Tyson Foods, Inc.*, 121 F.3d 642, 646 (11th Cir. 1997) (quoting *Matsuhita Elec. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986)).

B. Hartford Is Entitled to Summary Judgment Because Plaintiff Failed to Exhaust His Administrative Remedies.

"The Eleventh Circuit Court of Appeals has consistently held that 'plaintiffs in ERISA actions must exhaust available administrative remedies before suing in federal court.'" *Stephenson v. Provident Life & Accident Ins. Co.*, 1 F. Supp. 2d 1326, 1331 (M.D. Ala. 1998); *see also Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897, 899 (11th Cir. 1990); *Mason v. Continental Group, Inc.*, 763 F.2d 1219, 1225-27 (11th Cir. 1985). The policy concerns served by the exhaustion requirement include "helping to reduce the number of frivolous lawsuits under ERISA; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned." *Stephenson*, 1 F. Supp. 2d at 1331 (citing *Curry v. Contract Fab. Inc. Profit Sharing Plan*, 891 F.2d 842 (11th Cir. 1990)). "The very premise of the exhaustion requirement, therefore, is that the right to seek federal court review matures only after that requirement has been appropriately satisfied." *Springer*, 908 F.2d at 900.

In the present case, it is undisputed that although Hartford informed Plaintiff that he must pursue Hartford's appeals process prior to filing suit, Plaintiff failed to do so. It is, therefore, undisputed that Plaintiff did not exhaust his administrative remedies. As such, Hartford is entitled to summary judgment as a matter of law. *See Springer*, 908 F.2d at 901 (district court plainly abused its discretion by not dismissing claimant's lawsuit where she filed suit prior to appealing administrator's initial claim determination); *Merritt v. Confederation Life Ins. Co*., 881 F.2d 1034, 1035 (11th Cir. 1989) (district properly granted summary judgment to insurer where it was undisputed that claimant failed to pursue appeal procedures and, thus, had not exhausted administrative remedies); *Mason*, 763 F.2d at 1227 (district court properly granted summary judgment where claimants failed to exhaust administrative remedies); *see also Bickley v.*

Caremark Rx., Inc., 461 F.3d 1325 (11th Cir. 2006) (affirming dismissal of claimant's complaint because he filed suit prior to exhausting administrative remedies).

CONCLUSION

In the Eleventh Circuit, a plaintiff in an ERISA action must exhaust available administrative remedies prior to filing suit in federal court. In the instant case, it is undisputed that Plaintiff failed to do so. Hartford, therefore, is entitled to summary judgment in its favor as a matter of law.

Respectfully submitted,

s/ Anne Laurie Smith_____
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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing pleading has been served upon all parties by placing same in the United States mail, properly addressed and postage prepaid, as follows, and/or via the Court's electronic filing system.

Done this 28th day of November, 2007.

/s/ Anne Laurie Smith___

COUNSEL:

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EXHIBIT A

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
Endorsement

Policyholder: DESHAZO CRANE COMPANY, LLC

Group Policy No.: GLT/GL-218370

Effective Date: November 1, 1999

This endorsement forms a part of your Booklet-certificate which describes the provisions of the group policy specified above.

With respect to All Active Full-time Salaried Employees, Your Booklet-certificate is amended as follows:

1. The Elimination Period shown in the Schedule of Insurance of the Long Term Disability portion of Your Booklet-certificate is amended to read as follows:

   The Elimination Period is the period of time you must be Disabled before benefits become payable. It is the last to be satisfied of the following:
   1. the first 90 day(s) of any one period of Disability; or
   2. with the exception of benefits required by state law, the expiration of any Employer sponsored short term disability benefits or salary continuation program.

2. The Maximum Duration of Benefits Table shown in the Schedule of Insurance of the Long Term Disability portion of Your Booklet-certificate is amended to read as follows:

MAXIMUM DURATION OF BENEFITS TABLE

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 48 months, if greater
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

The above table shows the maximum duration for which benefits may be paid. All other limitations of the plan will apply.

Richard G. Costello, *Secretary* Thomas M. Marra, *President*

GROUP BENEFIT PLAN

DESHAZO CRANE COMPANY, LLC

Short Term Disability, Life and Accidental Death and Dismemberment

TABLE OF CONTENTS

Group Short Term Disability Benefits

A note on capitalization in this benefits booklet:

Capitalization of the first letter of a word or phrase not normally capitalized according to the rules of standard punctuation (Weekly Earnings, for example) indicates a word or phrase that is defined in the DEFINITIONS section, or that refers back to an item found in the Schedule of Benefits.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
as of the Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employees of the Policyholder who:

- are eligible for the insurance;
- become insured; and
- continue to be insured;

according to the terms of the Policy.

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

Richard G. Costello, *Secretary*

Thomas M. Marra, *President*

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder:	DESHAZO CRANE COMPANY, LLC
Group Insurance Policy:	GRH-218370
Plan Effective Date:	November 1, 1999

This plan of Short Term Disability Insurance provides you with short term income protection if you become Disabled from a covered accident, sickness or pregnancy.

Must you contribute toward the cost of coverage?
You do not contribute toward the cost of coverage.
Who is eligible for coverage?

Eligible Class(es):	All Active Full-time Hourly Employees
Full-time Employees:	30 hours weekly

The **Weekly Benefit** will be the lesser of:
- 66 2/3% of your Weekly Earnings; or
- $500,

reduced by Other Income Benefits.

The **Maximum Duration of Benefits** for a Disability is:
- 25 week(s) if caused by Accident;
- 25 week(s) if caused by Sickness.

Benefits Commence for Disability caused by:
- Accident: on the 8th day of Total Disability
- Sickness: on the 8th day of Total Disability

When will You become eligible? (Eligibility Waiting Period)
You will be eligible for coverage on the date on which You complete a waiting period of 30 days of continuous service.

The waiting period will be reduced by the period of time you were an Active Full-Time Employee with the Employer under the Prior Plan.

DEFINITIONS

The terms listed will have these meanings:

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. Such employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Full-time Employment shown in the Schedule of Insurance.

Actively at Work
You will be considered to be actively at work with the Employer on a day which is one of the Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a full time basis on that day. You will be deemed to be actively at work on a day which is not one of the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Current Weekly Earnings means the Weekly Earnings you receive from any employer or for any work while Disabled and eligible for Partial Disability benefits under this plan.

Disability means Total or Partial Disability.

Disabled means Totally or Partially Disabled.

Employer means the Policyholder.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorders, but excluding demonstrable structural brain damage.

Other Income Benefits mean the amount of any benefit for loss of income, provided to you as a result of the period of Disability for which you are claiming benefits under this plan. This includes any such benefits for which you are eligible, or that are paid to you, your family, or to a third party on your behalf. This includes the amount of any benefit for loss of income from:

1. the Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that you are eligible to receive because of your Disability;
2. any plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer, or as a result of membership in or association with any group, association, union or other organization;
3. the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability;
4. any governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
5. any temporary or permanent disability benefits under a workers' compensation law, occupational disease law, or similar law; or
6. individual insurance policy where the premium is wholly or partially paid by the Employer.

Other Income Benefits will also include the amount of any benefits for loss of income from:

1. the portion of a settlement or judgement, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings; or
2. compulsory "no-fault" automobile insurance.

Any general increase in benefits required by law that you are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If you are paid Other Income Benefits in a lump sum, we will pro-rate the lump sum:

1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined, over a period of 260 weeks.

Partial Disability or Partially Disabled means that, immediately following a period of Total Disability for which you were eligible to receive a Weekly Benefit, you are:

1. still prevented by the same disabling condition from performing essential duties of your occupation; but
2. you have recovered to the extent that you are:
   a) able to perform some, but not all, of the essential duties of your or any occupation; and
   b) as a result, you are earning more than 20% but no more than 80% of your pre-disability Weekly Earnings.

Physician means a practitioner of a healing art, which we are required by law to recognize, who is properly licensed, and practicing within the scope of that license.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Sickness vs. Accident
A Disability shall be deemed to be caused by sickness, and not by accident, if:
1. it is caused or contributed to by:
   a) any condition, disease or disorder of the body or mind;
   b) any infection, except a pus-forming infection of an accidental cut or wound;
   c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
   d) any disease of the heart;
   e) Mental Illness;
   f) Substance Abuse;
   g) pregnancy;
   h) any medical treatment for items (a) through (g) above; or
2. it is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means that you are prevented by:
1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability Weekly Earnings.

We, us or **our** means the Hartford Life and Accident Insurance Company.

Weekly Earnings means your usual weekly rate of pay, including commissions received from the Employer, but not:
1. overtime pay;
2. any fringe benefit or extra compensation; or
3. bonuses.

Commissions will be averaged as follows:
1. over the most recent 24 month period prior to the date your disability began; or
2. over the number of calendar months you worked for the Employer prior to becoming Disabled, if you have worked for the Employer at least 6 months but less than 24 months; or
3. commissions will not be included if you have worked for the Employer less than 6 months.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time Employee before becoming Totally Disabled.

You or **your** means the insured person to whom this Booklet-certificate is issued.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

When will you become eligible?
You will become eligible for coverage on either:
1. the Plan Effective Date, if you have completed the Eligibility Waiting Period; or if not
2. the date on which you complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

How do you enroll?
Eligible Persons will be enrolled automatically by the Employer.

WHEN COVERAGE STARTS

When does your coverage start?
If you are not required to contribute toward the plan's cost, your coverage will start on the date you become eligible.

DEFERRED EFFECTIVE DATE

Will coverage become effective if a disabling condition causes you to be absent from work on the date it is to start?
If you are absent from work due to your:
1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date your insurance or increase in coverage would otherwise have become effective, the effective date of the coverage or increase in coverage will be deferred until you have been Actively at Work for one full work-day.

CHANGES IN COVERAGE

Do coverage amounts change if there is a change in your class or your rate of pay?
Your coverage may increase or decrease on the date there is a change in your class or Weekly Earnings. However, no increase in coverage will be effective unless on that date you:
1. are an Active Full-time Employee; and
2. are not absent from work due to your being Disabled.

If you were so absent from work, the effective date of such increase will be deferred until you are Actively at Work for one full day.

No change in your Weekly Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the Plan?
Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, except that the limitations on increases stated in the Deferred Effective Date provision will apply.

BENEFITS

How do benefits become payable for Total Disability?
If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of all Other Income Benefits, including any amount for which you could collect but did not apply.

See the Schedule of Insurance for the Weekly Benefit, the Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless you are under the care of a Physician other than yourself.

PARTIAL DISABILITY BENEFITS

How are benefits paid for Partial Disability?
After benefits have commenced for Total Disability, if you return to work on a part-time or limited duty basis because you are Partially Disabled, the following calculation is used to determine your Weekly Benefit:

$$\text{Weekly Benefit} = ((A - B) / A) \times C$$

Where

A = Your pre-disability Weekly Earnings.
B = Your Current Weekly Earnings.
C = The Weekly Benefit payable if you were Totally Disabled.

How is a benefit calculated for a period of less than a week?
If a Weekly Benefit is payable for less than a week, we will pay 1/5 of the Weekly Benefit for each day you were Disabled.

When will benefit payments cease?
Benefit payments will stop on the first to occur of:
1. the date you are no longer Disabled;
2. the date you fail to furnish proof that you continue to be Disabled;
3. the date you refuse to be examined, if we require an examination;
4. the last day benefits are payable according to the Maximum Duration of Benefits shown in the Schedule of Insurance; or
5. the date you die.

RECURRENT DISABILITY

What happens to your benefits if you return to work as an Active Full-time Employee and then become Disabled again?
If you return to work as an Active Full-time Employee for 15 consecutive days or more, any recurrence of a disability will be treated as a new Disability with respect to when Benefits Commence and the Maximum Duration of Benefits, as shown in the Schedule of Insurance.

If recurrent periods of Disability are:
1. due to the same or a related cause; and
2. separated by less than 15 consecutive days of work as an Active Full-time Employee,

they will be considered to be the same period of Disability.

MULTIPLE CAUSES

How long will benefits be paid if a period of Disability is extended by another cause?
If a period of Disability is extended by a new cause while weekly benefits are payable, weekly benefits will continue while you remain Disabled, subject to the following:
1. weekly benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2. the Exclusions will apply to the new cause of Disability.

EXCLUSIONS

What Disabilities are not covered?
The plan does not cover, and no benefit shall be paid for, any:
1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability caused by your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
4. Disability caused or contributed to by an intentionally self-inflicted injury;
5. sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed; or
6. injury sustained as a result of doing any work for pay or profit for another employer.

If you are receiving, or are eligible to receive, benefits for a Disability under a prior plan of disability benefits that:
1. was sponsored by the Employer; and
2. was terminated on the day before the Effective Date of this plan,

then no benefits will be payable for the Disability under this plan.

TERMINATION

When does your insurance terminate?
Your insurance will terminate on the earliest of:
1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution;
5. the date on which you cease to be an Active Full-time Employee in an eligible class, including:
   a) temporary layoff;
   b) leave of absence, including but not limited to leave for military service;
   c) work stoppage (including a strike or lockout); or
   d) the date your Employer ceases to be a Participant Employer, if applicable.

May coverage be continued during a family or medical leave?
If you are granted a leave of absence according to the Family and Medical Leave Act of 1993, your Employer may continue your insurance for up to 12 weeks, or longer if required by state law, following the date your coverage would have terminated, subject to the following:
1. the leave authorization must be in writing;
2. the required premium for you must be paid;
3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the day before said leave commenced; and

4. such continuation will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the termination of the Group Insurance Policy;
   c) non-payment of premium when due by the Policyholder or you;
   d) the Group Insurance Policy no longer insures your class; or
   e) the date your Employer ceases to be a Participant Employer, if applicable.

Does your insurance continue while you are Disabled and no longer an Active Full-time Employee?
If you are no longer an Active Full-time Employee because you are Disabled, your Short Term Disability Insurance will be continued:
1. while you remain Disabled;
2. without payment of premium after the date we receive written notice of claim; and
3. until the end of the period for which you are entitled to receive Short Term Disability Benefits.

After Short Term Disability benefit payments have ceased, your insurance will be reinstated, provided:
1. you return to work for one full day as an Active Full-time Employee in an eligible class;
2. the Group Insurance Policy remains in force; and
3. the required premium is paid.

Do benefits continue if the Group Insurance Policy terminates?
If you are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:
1. will continue as long as you remain Disabled by the same disabling condition; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no affect on our liability under this provision.

GENERAL PROVISIONS

What happens if facts are misstated?
If material facts about you were not stated accurately:
1. your premium may be adjusted; and
2. the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by you relating to your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during your lifetime. In order to be used, the statement must be in writing and signed by you.

When should we be notified of a claim?
You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as reasonably possible. Such notice must include your name, your address and the Group Insurance Policy number.

Are special forms required to file a claim?
When we receive a notice of claim, you will be sent forms for providing us with proof of loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

When must proof of loss be given?
Written proof of your Disability must be sent to us within 90 days after the start of the period for which we owe payment. After that, we may require further written proof that you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as reasonably possible; but
3. not later than 1 year after it is due, unless you are not legally competent.

We have the right to require, as part of the proof of loss:
1. your signed statement identifying all Other Income Benefits; and
2. proof satisfactory to us that you and your dependents have duly applied for all Other Income Benefits which are available.

May additional proof be required?
We may have you examined to determine if you are Disabled. Any such examination will be:
1. at our expense; and
2. as reasonably required by us.

We reserve the right to determine if your proof of loss is satisfactory.

Who gets the benefit payments?
All payments are payable to you. Any payments owed at your death may be paid to your estate. If any payment is owed to your estate, we may pay up to $1,000 to any of your relatives who is entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid.

When are payment checks issued?
If written proof of loss is furnished, accrued benefits will be paid at the end of each week that you are Disabled. If payment is due at the end of a claim, it will be paid as soon as the written proof of loss is received.

What notification will you receive if your claim is denied?
If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:
1. give the specific reason(s) for the denial;
2. make specific reference to the policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

What recourse do you have if your claim is denied?
On any denied claim, you or your representative may appeal to us for a full and fair review. You may:
1. request a review upon written application within 60 days of the claim denial;
2. review pertinent documents; and
3. submit issues and documents in writing.

We will make a decision no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific references to the policy provisions on which the decision is based.

When can legal action be started?
Legal action cannot be taken against us:
1. sooner than 60 days after due proof of loss has been furnished; or
2. later than the expiration of:
   a) 3 years; or if longer
   b) the period of time stated in the applicable Statute of Limitations,

   after the time written proof of loss is required to be furnished according to the terms of the Group Insurance Policy.

What are our subrogation rights?
If you:

1. suffer a Disability because of the act or omission of a third party;
2. become entitled to and are paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights you may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability. Such right may be exercised only if you have been, or will be, fully compensated for the lost wages.

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.

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Group Life Insurance Benefits

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
As of the
Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that We have issued and delivered the Group Insurance Policy (Policy) to the Policyholder. The Policy insures the Policyholder's employees who:

- are eligible for the insurance;
- become insured; and
- continue to be insured,

according to the terms of the Policy.

The terms of the Policy which affect an employee's insurance are summarized in the following pages.

This Certificate of Insurance, and the following pages, will become Your Booklet-certificate. The Booklet-certificate is a part of the Policy. This Booklet-certificate replaces any other which We may have issued to the Policyholder to give to You under the Policy specified herein.

Richard G. Costello, *Secretary*

Thomas M. Marra, *President*

Some of the terms used within this Booklet-certificate are capitalized and have special meanings. Please refer to the definitions at the end of this Booklet-certificate when reading about Your benefits.

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

The Policyholder:	DESHAZO CRANE COMPANY, LLC
The Policy Number:	GL-218370
Policy Effective Date:	November 1, 1999
Anniversary Date:	November 1 of each year, beginning in 2000.

Who is eligible for coverage?
Eligible Class(es): All Active Full-time Hourly Employees

When will You become eligible? (Eligibility Waiting Period)
You will be eligible for coverage on the date on which You complete a waiting period of 30 days of continuous service.

The waiting period will be reduced by the period of time You were an Active Full-time Employee with the Employer under the Prior Plan.

What is Evidence of Good Health?
Evidence of Good Health is information about a person's health from which We can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by Us.

Inquiries as to the status of Your submission of Evidence of Good Health should be addressed to Your Employer and/or Benefit Administrator. Your Employer and/or Benefit Administrator will notify You of approvals. We will notify You, in writing, of any disapprovals.

When will Evidence of Good Health be required?
Evidence of Good Health is required if You elect no coverage for Yourself when eligible to do so and later opt for coverage.

If Evidence of Good Health is not approved in the situation(s) described above, no coverage will become effective. Evidence of Good Health must be provided at Your own expense.

AMOUNT OF LIFE INSURANCE
Employee Only

What Life benefits are available to You?

Amount of Life Insurance:
An amount equal to 1 times Your annual rate of basic Earnings, rounded to the next higher multiple of $1,000, subject to a maximum of $250,000.

In no event however will Your Amount of Life Insurance be less than $10,000.

Your Amount of Life Insurance will be reduced by any life benefit:
1. paid to You under an accelerated death benefit in the Prior Plan; and
2. in force for You under any disability extension provision of the Prior Plan.

If You convert, does it affect the Amount of Life Insurance benefit payable?
The Amount of Life Insurance under the Policy will be reduced by the amount of the individual life insurance issued in accordance with the Conversion Privilege for reasons other than reductions in coverage.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT (AD&D) Employee Only

What AD&D Benefits are available to You?

Principal Sum:
An amount which equals the Amount of Life Insurance in force for You.

The Principal Sum will not exceed the Amount of Life Insurance for which You are insured.

Reduced Amounts of Insurance

What reductions in Your coverage will occur due to Your age?
Your Amount of Life Insurance and Principal Sum will decrease on the Anniversary Date which occurs on or next follows the date You attain any of the ages specified in the following table. The Amount of Life Insurance and Principal Sum in force immediately prior to that Anniversary Date will be reduced by the percentage indicated in the following table.

Additionally, if:
1. You become insured under the Policy; or
2. Your coverage increases,

on or after the date You attain age 65, We reduce the amount of coverage for which You would otherwise be eligible in the same manner.

Age When Reduction Occurs	65	70	75	80	85	90	95
Percentage by which current amount of coverage (after all previous reductions) will be reduced	35%	35%	35%	25%	25%	25%	25%

Reduced amounts of Life Insurance and Principal Sum will be rounded to the next higher multiple of $500, if not already such a multiple.

Eligibility and Enrollment

Must You contribute toward the cost of coverage?
With respect to Life Insurance and AD&D coverage, You do not contribute toward the cost.

How do You request coverage for Yourself?
If You are not required to contribute toward the cost of coverage, You are not required to request coverage. Enrollment will be automatic. However You will be required to complete a beneficiary election form.

If You must contribute toward the cost of coverage, You are required to enroll for coverage. To do so You must complete and sign a group insurance enrollment form acceptable to Us and deliver it to the Employer.

When does coverage start?
If You are not required to contribute toward the cost of coverage, You will become insured on the date You become eligible for coverage.

If You must contribute toward the cost of coverage, You will become insured on the first to occur of:
1. the date You are eligible, if You enroll on or before that date;
2. the date You enroll, if You enroll within 31 days after the date You become eligible.

If You enroll more than 31 days after the date You first become eligible to do so, no coverage will be available without Evidence of Good Health.

Coverage for which We require Evidence of Good Health will become effective on the later of:
1. the date You become eligible; or
2. the date approved by Us.

All effective dates of coverage are subject to the Deferred Effective Date provision.

What is the Deferred Effective Date provision for employees?
If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time Employee.

Are there exceptions to the Deferred Effective Date provision?
If You were actively at work or on an approved leave of absence in conformity with the Family or Medical Leave Act of 1993, and insured under the Prior Plan on the day before the Policy Effective Date and You would be eligible for coverage on the Policy Effective Date except that You are not able to meet the requirements of the Deferred Effective Date provision, then:
1. the Deferred Effective Date provision will not apply to the original effective date of coverage; and
2. the coverage amount shown in the Schedule of Insurance will not apply to You.

Instead, You will be considered to be insured and your coverage amount will be the lesser of:
1. the Amount of Life Insurance and Principal Sum under the Prior Plan; or
2. the Amount of Life Insurance and Principal Sum shown in the Schedule of Insurance,

reduced by:
1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

You will remain insured under this provision until the first to occur of:
1. the date You return to work as an Active Full-time Employee;
2. the date Your insurance terminates for a reason stated under the Termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day You would have been covered under the Prior Plan, had the Prior Plan not terminated.

When are changes effective?
The provisions, terms and conditions of the Schedule of Insurance or this Booklet-certificate may be modified, amended or changed at any time; consent from any covered individual is not required.

If there is any type of change in Your class, Earnings, the Schedule of Insurance or the Booklet-certificate which:
1. decreases an amount of coverage or deletes, limits or restricts the availability of a benefit or provision, then that decrease, deletion, limitation or restriction will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective;
2. increases an amount of coverage or adds, improves or increases availability of a benefit or provision, then that increase, addition or improvement will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective, subject to application of the Deferred Effective Date provision and Our approval where Evidence of Good Health is required.

BENEFITS

Life Insurance Benefit

To whom and how are benefits paid?
A completed claim form, a certified copy of the death certificate and Your enrollment form must be sent to the Employer or Us. When the required claim papers are received and approved by Us, the Amount of Life Insurance will be paid.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by You in writing and on file with the Employer.

Unless You have requested something different, payment will be made as follows:
1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1. up to $500 of Your life insurance to any party that We deem is entitled because of their payment of burial expenses. We will be released from further liability for any amount so paid; and/or
2. the executors or administrators of Your estate; or
3. Your surviving relatives in the following order:
   a) all to Your surviving spouse; or
   b) if Your spouse does not survive You, in equal shares to Your surviving children; or
   c) if no child survives You, in equal shares to Your surviving parents.

If a minor does not have a legal guardian, We may, until such a guardian is appointed, pay the person We deem to be caring for and supporting him. Such payment will be in monthly installments of not more than $200.

If a death benefit payable meets Our guidelines, then the benefit is payable into a checking account. Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

Accelerated Death Benefit

What is the benefit?
If You are diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and You are:
1. less than age 60; and
2. insured for at least $10,000,

then You may request that a portion of Your Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of $3,000 and a maximum of $500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to $20,000 and You are Terminally Ill, You can request any portion of the life insurance between $3,000 to $16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only $3,000 now, You cannot request the additional $13,000 in the future.

What does Terminal Illness/Terminally Ill mean?
Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.

What if an individual is no longer Terminally Ill?
If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

What limitations apply to this benefit?
The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

What if You made an assignment under this plan?
If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

Accidental Death and Dismemberment (AD&D) Benefit
Employee Only

What conditions are necessary for benefits to become payable?
We will pay a benefit if You suffer an accidental injury while insured and:
1. a Loss results directly from such injury, independent of all other causes; and
2. such Loss occurs within 90 days after the date of the accident causing the injury.

When should We be notified of a claim?
A claimant must give Us, or Our appropriate representative, written notice of a claim within 20 days after the loss happens or starts. If notice cannot be given within that time, it must be given as soon as possible after that.

Such notice must include:
1. the claimant's name and address; and
2. the Policy or account number.

Are special forms required to file a claim?
Within 15 days of receiving a notice of claim, We or Our appropriate representative will send forms to the claimant for providing proof of loss. If the forms are not provided within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of claim.

When must Proof of Loss be given?
Satisfactory written proof of loss must be sent to Us or Our appropriate representative, within 90 days after the date of such loss. However, all claims must be submitted to Us within 90 days of the date any individual's insurance terminates.

If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible, but no later than a year after it is due unless the claimant is not legally competent.

When and to whom will Your claim be paid?
Benefits for Loss of life will be paid in accordance with Your life insurance beneficiary designation. Unless otherwise specified, benefits for all other Losses are payable to You.

Benefits for all other Losses will be paid as soon as due written proof is received. Benefits for all other Losses will be paid not more than 60 days after written proof is received.

Any payments, other than for Loss of life, which are owing at Your death may be paid to Your estate. If any payment is owed to:
1. Your estate;
2. a person who is a minor; or
3. a person who is not legally competent,

then We may pay up to $1,000 to Your relative who is entitled to it in Our opinion. Any such payment shall fulfill Our responsibility for the amount paid.

What types of injuries are excluded from coverage?
No benefit will be paid for a Loss caused or contributed to by:
1. sickness;
2. disease;
3. any medical treatment for items (1) or (2);
4. any infection, except a pus-forming infection of an accidental cut or wound;
5. war or any act of war, whether war is declared or not;
6. any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7. any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;
8. taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered by a licensed physician; or
9. the injured person's intoxication.

Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level, meet or exceed the legal presumption of intoxication under the law of the state where the accident took place.

What is the benefit payable?
The benefit payable for any Loss is that which is shown opposite the Loss in the following schedule. The Principal Sum is shown in the Schedule of Insurance. No benefit is payable for any Loss which is not shown in the schedule below.

DESCRIPTION OF LOSS	BENEFIT
Loss of life	Principal Sum
Loss of a hand	One-half the Principal Sum
Loss of a foot	One-half the Principal Sum
Loss of an eye	One-half the Principal Sum
Loss of Speech or Hearing	One-quarter the Principal Sum
Loss of movement of both upper and lower limbs (Quadriplegia)	One-half the Principal Sum
Loss of movement of both lower limbs (Paraplegia)	One-quarter the Principal Sum
Loss of movement of both upper and lower limbs on one side of the body (Hemiplegia)	One-quarter the Principal Sum
More than one of the above resulting from one accident	Principal Sum or the sum of the Benefits payable for each

Loss, whichever is lesser.

Loss means the following:
1. Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint.
2. Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.
3. Loss of speech or hearing means that speech or hearing is lost entirely and the Loss cannot be recovered or restored. Hearing must be lost in both ears.
4. Loss of movement of limbs means that movement is completely lost and is irreversible.

Are there any additional benefits?

Felonious Assault
Subject to all conditions and limitations of this AD&D Benefit, if You are injured as the result of a Felonious Assault, then a Felonious Assault Benefit is payable in addition to the Principal Sum.

What is the Felonious Assault Benefit payable?
The Felonious Assault Benefit payable is the lesser of:
1. one times Your annual rate of basic Earnings rounded to the next higher $1,000;
2. $25,000; or
3. an amount equal to the Principal Sum.

Felonious Assault means a violent or criminal act directed at You during the course of:
1. a robbery, hold-up or kidnapping involving Employer funds; or
2. an attempt at any of the above.

Such Felonious Assault must:
1. occur while You are on the Premises of or conducting the Business of the Employer;
2. be directly related to Your employment with the Employer; and
3. not be committed by an employee of the Employer or Your family member.

Premises means any real estate owned, leased, controlled or managed by the Employer for the purposes of conducting the business of the Employer.

Business means any trip at the direction of the Employer for the purpose of furthering the business of the Employer. Business does not mean everyday travel to and from work, bona fide leaves of absence or vacations, outings or other Employer-sponsored employee or retiree events.

Seat Belt Coverage
Subject to all conditions and limitations of this AD&D Benefit, if You die from injuries sustained in a Motor Vehicle, a Seat Belt Benefit will be paid in addition to the Principal Sum. This benefit is payable provided that:
1. the injury occurs while the individual is a passenger riding in or the licensed operator of a duly registered Motor Vehicle; and
2. the individual is wearing a Seat Belt at the time of the Accident, as verified on the police accident report.

What is the Seat Belt Benefit payable?
The Seat Belt Benefit payable is equal to 25% of the Principal Sum.

Accident, for the purposes of this Seat Belt Benefit, means the unintentional collision of a Motor Vehicle.

Motor Vehicle means a four-wheeled, private passenger car, pickup truck, station wagon, van or jeep-type vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Employer, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means a belt, lap restraint, or shoulder restraint installed by the manufacturer of the Motor Vehicle.

Education Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then an Education Benefit will be paid in addition to the Principal Sum. This benefit is payable to each of Your dependents who qualifies as a Student.

Who may qualify as a Student?
A Student, for the purpose of this Education Benefit, means a person who is Your dependent on the date of Your death and who:
1. is a post-high school student who attends a school for higher learning on a Full-time basis on the date of Your death; or
2. became a Full-time, post-high school student in a school for higher learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

The term "Full-time" student shall mean registered for not less than 12 course credit hours per semester. If the institution establishes full-time student status by a method other than semester credit hours, We reserve the right to determine whether the student qualifies as Full-time. No benefit is payable to any dependent who has not furnished proof to Us of his Student status.

What is the Education Benefit payable?
The Education Benefit payable is the lesser of:
1. $5,000;
2. 5% of the Principal Sum; or
3. the actual tuition expense for any one school year.

We will not pay more than one Education Benefit per Student during any one school year. If the Student is a minor, We will pay benefits to the Student's legal representative.

When will payments terminate?
The Education Benefit will no longer be payable on the first to occur of:
1. the date on which the fourth Education Benefit has been paid; or
2. the end of the 12th consecutive month during which the dependent has not furnished satisfactory proof to Us that he is a Student.

What benefits are payable if no dependent qualifies as a Student?
If no dependent qualifies as a Student, then We will pay $1,000 in accordance with Your beneficiary designation.

Day Care Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Day Care Benefit is payable in addition to the Principal Sum. The Day Care Benefit is payable for each dependent if:
1. such dependent is less than age 7 at the time of death; and
2. proof of such dependent's enrollment in a Day Care Program is provided as described below.

What is the Day Care benefit payable?
The Day Care Benefit payable is the lesser of:
1. $10,000; or
2. 5% of Your Principal Sum.

One Day Care Benefit is payable each year for each dependent who qualifies for Day Care Benefits. No more than two Day Care Benefits will be payable for each dependent. Payment will be made to the person who has primary responsibility for such dependent's expenses.

What proof must be given?
Proof of a dependent's enrollment in a Day Care Program may be in the form of, but will not be limited to, the following:
1. a copy of the dependent's approved enrollment application in a Day Care Program;
2. canceled check(s) which prove payment for a Day Care Program; or
3. a letter from the Day Care Program stating that the Dependent:

a) is attending a Day Care Program; or
b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of Your death.

Proof of enrollment must be sent to Us prior to the last day of the 12th month on or next following the date of Your death.

Day Care Program means a program of child care which;
1. is operated in a private home, school or other facility;
2. provides and charges a fee for the care of children; and
3. is licensed as a Day Care Center or is operated by a licensed Day Care Provider, if such licensing is required by the state or jurisdiction in which it is located; or
4. if licensing is not required, provides child care on a daily basis for 12 months a year.

A Day Care Program will not mean a program of child care which is provided by an immediate relative of the child receiving the care. An immediate relative is a sibling, parent, step-parent, grandparent, aunt, or uncle.

What benefits are payable if no person is eligible for Day Care Benefits?
If no dependent qualifies for Day Care Benefits, then We will pay $500 in accordance with Your beneficiary designation.

TERMINATION
Employee Coverage

When does Your coverage terminate?
Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:
1. the date the Policy terminates;
2. the last day of the period for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the date Your Employer terminates Your employment; or
5. the date You are absent from work as an Active Full-time Employee.

EXCEPTIONS TO TERMINATION

Under what conditions can Your insurance be continued under the continuation provisions?
If You are absent from work as an Active Full-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:
1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are on a documented leave of absence, other than Family or Medical Leave, all of Your coverages may be continued until the last day of the month following the month in which the leave of absence commenced.

If You are laid off due to lack of work, all of Your coverages may be continued until the last day of the month following the month in which the layoff commenced.

If Your employment status changes from full-time to part-time, all of Your coverages may be continued until the last day of the third consecutive month after the date You became a part-time employee.

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, all of Your coverages may be continued for up to 12 weeks, or longer if required by state law, following the date Your insurance would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level will be that which was in effect on the day before said leave started, subject to any reductions included in the Policy;
4. the amount of Earnings upon which Your benefit may be based, will be that which was in effect on the day before said leave started; and
5. continued coverage will cease immediately if one of the following events should occur;
   a) the leave terminates prior to the agreed upon date;
   b) the Policy terminates;
   c) You or the Policyholder fail to pay premium when due; or
   d) the Policy no longer insures Your class.

In all other respects, the terms of Your insurance remain unchanged.

If You are absent from work due to sickness or injury, all of Your coverages may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time Employee. If You feel that Your condition may continue for an extended period of time, You should request that Your Employer file a waiver of premium claim.

What is Waiver of Premium?
Waiver of premium is a provision which allows for continued employee life insurance, without payment of premium, while You are Disabled.

To what coverages does the Waiver of Premium apply?
These provisions apply only to Your Life Insurance.

Waiver of Premium does not apply to any AD&D Insurance.

What conditions must be satisfied before You qualify for Waiver of Premium?

1. You must be less than age 60, insured and Disabled; and
2. acceptable proof of Your condition must be furnished to Us within one year of Your last day of work as an Active Full-time Employee.

What does Disabled mean?
Disabled means that You have a condition that prevents You from doing any work for which You are or could become qualified by education, training or experience and it is expected that this condition will last for at least nine consecutive months from Your last day of work as an Active Full-time Employee; or You have been diagnosed with a life expectancy of 12 months or less.

When will We waive premium?
We will waive premium after proof that You are Disabled is provided by an attending physician licensed to practice in the United States and We approve the proof. You will be notified by Us of the date We will begin to waive premium.

Continued coverage will be subject to any age reductions provided by any part of the Policy.

What if You die before You qualify for Waiver of Premium?
If:

1. You should die within one year of Your last day of work as an Active Full-time Employee but prior to qualifying for waiver of premium; and
2. You were Disabled,

We will pay the Amount of Life Insurance which is in force for You.

Can We have You examined for proof that You continue to be Disabled?
During the first two years following the date You qualify as Disabled, We may have You examined at reasonable intervals. Thereafter, We will only require an annual examination to confirm that You continue to be Disabled. If You fail to submit any required proof or refuse to be examined as required by Us, then Your coverage will terminate.

What if You are no longer Disabled?
If, for any reason, You are no longer Disabled, Your premium will no longer be waived. On that date, You may or may not return to work.

If You return to work in an Eligible Class, then all of Your coverages will be reinstated subject to the terms of the Policy in effect on the reinstatement date.

If You do not return to work within an Eligible Class, and You are not eligible for any other group life insurance, then You are entitled to the Conversion Privilege. You may convert the Amount of Life Insurance that is in force for You on the date it is determined that You are no longer Disabled.

How long will premiums be waived?
Your premium will be waived and Your coverage will be continued until You attain Normal Retirement Age.

On the date waiver of premium terminates, if You do not return to work, You will be entitled to convert Your coverage. You may convert no more than Your Amount of Life Insurance that is in force on the date waiver of premium terminates.

What if the Policy terminates before You qualify for waiver of premium?
If the Policy terminates before You qualify for waiver of premium, You may be eligible to convert. Additionally, You may later be approved for waiver of premium.

What if the Policy terminates after You qualify for waiver of premium?
Termination of the Policy will not affect Your coverage under the terms of this provision.

CONVERSION PRIVILEGE

The following does not apply to any AD&D Benefits.

When can an individual convert?
If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

If the qualifying event is policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy in order to be eligible for this conversion privilege.

What is the conversion policy?
The conversion policy will:
1. be on one of the life insurance policy forms, except term insurance, then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

How much can be converted?
If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:
1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage; or
2. $2,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

How does an individual convert coverage?
To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to Us and pay the premium required for his age and class of risk.

What if death occurs during the conversion election period?
If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

GENERAL PROVISIONS

When can this plan be contested?
Except for non-payment of premium, the Policy cannot be contested after two years from the Policy Effective Date.

No statement relating to insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the individual's lifetime. In order to be used, the statement must be in writing and signed by the affected individual.

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Are there any rights of assignment?
Except for the dismemberment benefits under the AD&D Benefit, You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:
1. the right to make any contributions required to keep the insurance in force;
2. the privilege of converting; and
3. the right to name and change a beneficiary.

No absolute assignment of rights and interest shall be binding on Us until and unless:
1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:
1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

How do You designate or change Your beneficiary?
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to Us prior to Your death will be accepted.

Designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

Can We have a claimant examined or request an autopsy?
We reserve the right to have a claimant examined and to have an autopsy performed, if not forbidden by law. Any such examinations will be as reasonably required by Us and at Our expense.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written decision will:
1. give the specific reason(s) for the denial;
2. make specific reference to the provisions upon which the denial is based; and
3. provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any denied claim, the claimant or His representative may appeal to Us for a full and fair review.

The claimant may:
1. request a review upon written application within 60 days of receipt of claim denial;
2. review pertinent documents; and
3. submit issues and comments in writing.

A request for an appeal will not be denied if not submitted within 60 days if it is not reasonably possible to make such request within 60 days. In this case, the request must be submitted as soon as reasonably possible thereafter.

A decision will be made by Us no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no event more than 120 days after the request for review is received.

When can legal action be taken?
Legal action cannot be taken against Us:
1. sooner than 60 days after proof of loss has been furnished; or
2. 3 or more years after the time proof of loss is required to be furnished according to the terms of the Policy.

How does this plan affect Workers' Compensation coverage?
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Physician-patient Relationship
You may choose any licensed physician. We shall not in any way disturb the physician-patient relationship.

DEFINITIONS

Active Full-time Employee – An employee who works for the Employer on a regular basis in the usual course of the Employer's business. An employee must work at least the number of hours in the Employer's normal work week. This must be at least 30 hours. You will be considered actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a full-time basis on that day. You will also be considered actively at work on a paid vacation day or a day which is not one of Your Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

Anniversary Date – The date occurring in each calendar year which is an anniversary of the Policy Effective Date.

Earnings – Regular pay, not counting overtime pay or any other pay or fringe benefits.

The term Earnings will include commissions. The amount of commissions included will be average commissions earned from this Employer during the 24 months immediately prior to the Anniversary Date.

If You have worked for less than 12 months with this Employer, the amount of commissions included will be based on the total commissions You actually received while working for this Employer immediately prior to the Anniversary Date.

Employer – The Policyholder named in the Schedule of Insurance.

He/His – He or she. His or her.

Normal Retirement Age – The Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth.

Prior Plan – A plan of group term life insurance sponsored by the Employer which was in force on the day before the Policy Effective Date.

We/Us/Our – The Hartford Life and Accident Insurance Company.

You/Your – The employee to whom this Booklet-certificate is issued.

ERISA

The Following Important Notice is Provided by Your Employer for your Information Only.

Conforming Instrument

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your booklet are provided under a group policy by the Insurance Company and are subject to the terms and conditions of that policy.

A copy of this policy is available for your review during normal working hours in the office of the Plan Administrator.

1. **Plan Name**

   Group Short Term Disability And Life Plan for employees of DESHAZO CRANE COMPANY, LLC

2. **Plan Number**

   501

3. **Employer/Plan Sponsor**

   DESHAZO CRANE COMPANY, LLC
   Airpark Industrial Road
   Alabaster, AL 35007

4. **Employer Identification Number**

   63-1169999

5. **Type of Plan**

   Welfare Benefit Plan providing Group Short Term Disability and Life.

6. **Plan Administrator**

   DESHAZO CRANE COMPANY, LLC
   Airpark Industrial Road
   Alabaster, AL 35007

7. **Agent for Service of Legal Process**

For the Plan:

DESHAZO CRANE COMPANY, LLC
Airpark Industrial Road
Alabaster, AL 35007

For the Policy:

Hartford Life And Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group policy.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the plan administrator's office and at other locations (work-sites and union halls), all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claim Procedures

1. Claims for Benefits -- An employee wishing to present a claim for benefits for himself or his insured dependents should obtain a claim form or forms from his Employer or Administrator. The applicable section of such form or forms should be completed by (1) Employee, (2) Employer or Administrator and (3) Attending Physician or Hospital.

   Following completion, the claim form or forms should be forwarded to the individual authorized to process and pay claims (Administrator or Insurance Company's Claim Representative). The individual authorized to process and pay the claims will compute benefits due, and will issue draft(s) in settlement. Unless the employee assigns benefits to a doctor or to a hospital, draft(s) will be made payable to the employee.

   A decision will be made by the Insurance Company no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.

2. Appealing Denial of Claims -- If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the employee. This written decision will:
   a) give the specific reason or reasons for denial;
   b) make specific reference to policy provisions on which the denial is based;
   c) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
   d) provide an explanation of the review procedure.

   On any denied claim an employee or his representative may appeal to the Insurance Company for a full and fair review. The claimant may:
   a) request a review upon written application within 60 days of receipt of claim denial;
   b) review pertinent documents; and
   c) submit issues and comments in writing.

   A decision will be made by the Insurance Company no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.

EXHIBIT B

February 4, 2005

James L. Harris
P.O. Box 1672
Clanton, AL 35046

Policy Holder: Deshazo Crane Company, Llc
Claimant: James L. Harris
Policy Number: GRH 218370

Dear Mr. Harris:

We are writing to you about your claim for Short Term Disability (STD) benefits. These benefits are under the group insurance policy number GRH 218370 for Deshazo Crane Company, Llc.

We have completed our review of your claim for benefits and have determined that this disability is related to your occupation.

Your policy states: "If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance."

"What Disabilities are not covered?
The plan does not cover, and no benefit shall be paid for, any:
1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability caused by your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
4. Disability caused or contributed to by an intentionally self-inflicted injury;
5. **sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed; or**
6. injury sustained as a result of doing any work for pay or profit for another employer."

We based our decision to deny your claim on policy language. All the papers contained in your file were viewed as a whole. This included:

- ***Your STD application.***

You have advised that your disability is related to your occupation as a welder. Specifically, you stated that "welding injured my eyes". Based on this information and how it relates to the

Benefit Management Services
Syracuse Disability Claim Office
P.O. Box 4925
Syracuse, NY 13221-4925
Fax (315) 474-1948

policy guidelines listed above, we are unable to approve your disability benefits at this time.

The following information, not previously submitted, is necessary for a determination of your claim: specifically,

1) a letter of denial from Workers' Compensation, and
2) a signed/dated Workers' Compensation Reimbursement Agreement (enclosed).

If you would like this information considered, we must receive it as soon as possible. Please send it to the claim office at the address shown on this letterhead.

The Employee Retirement Income Security Act of 1974 ("ERISA") gives you the right to appeal our decision and receive a full and fair review. You may appeal our decision even if you do not have new information to send to us. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If you do not agree with our denial, in whole or in part, and you wish to appeal our decision, you or your authorized representative must write to us within one hundred eighty (180) days from the date of this letter. Your appeal letter should be signed, dated and clearly state your position. Along with your appeal letter, you may submit written comments, documents, records and other information related to your claim.

Once we receive your appeal, we will again review your entire claim, including any information previously submitted and any additional information received with your appeal. Upon completion of this review, we will advise you of our determination. After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA. We reserve all rights and defenses available to us in making our determination.

Please send your appeal letter to:

The Hartford
Attn: Appeal Unit
P.O. Box 4925
Syracuse, NY 13221-4925

If you have any questions, please feel free to contact our office at (800) 538-8439. Our office hours are 8:00 AM to 6:00 PM EST, Monday through Friday.

Sincerely,

Andrew E. Walton, Examiner
Hartford Life and Accident Insurance Co.

Benefit Management Services
Syracuse Disability Claim Office
P.O. Box 4925
Syracuse, NY 13221-4925
Fax (315) 474-1948